IDAHO DEPARTMENT OF HEALTH & WELFARE

Notification of Change Form

Bureau of Long Term Care

Participant Name				Medicaid #	
Date		Region		IDHW Fax#	(208)639-5731
Agency		Agency Contact		Agency Phone#	

	☐ Participant in Skilled Nursing Facility	Date Entered:
	☐ Participant in Residential Assisted Living	Date Entered:
	☐ Participant in hospital	Date Admitted: Reason for Admission:
	☐ Participant discharged from hospital	Date Discharged:
	☐ Participant has moved Date Moved:	New Address: New Phone Number:
	☐ Participant is no longer receiving services	Date Services Ended: Reason Services Ended:

Termination of participant services require a 14-day notification. 14-day termination rules do not apply to Non-Payment of Share of Cost or Caregiver Safety Risk. A narrative must be included for these instances.

	☐ Caregiver Health & Safety Risk (Please Specify):	☐ Non-Payment by Participant
	☐ Other (Please Specify):	☐ Medicaid response is required. (Please Specify):

After form is complete, please fax to (208)639-5731

Email (Click Region Below):
Region1 – Region2 – Region3 – Region4 – Region5 – Region6 – Region7